PSYCHOLOGICAL CASE RECORD

Submitted to the Tamil Nadu Dr. M.G.R. Medical University in partial fulfillment of the requirements for the Diploma in Psychological Medicine Examination 2017

By

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Most of all, I would like to thank God Almighty for all His blessings.

CERTIFICATE

This is to certify that this Psychological Case Record is a bonafide record of work done by **Dr. Cheruba Susan George** during the years 2016-2018. I also certify that this record is an independent work done by the candidate under my supervision.

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Mrs. Sushila Russell, M.Phil.

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CASE RECORD 1: Neuropsychological Assessment

Name	: Mr. G
Age	: 54 years
Sex	: Male
Marital status	: Married
Religion	: Hindu
Language	: Tamil
Education	: 8th grade
Occupation	: Agricultural Business
Socio-economic status	: Lower Middle
Residence	: Urban
Informant	: Mr. G and his wife

Presenting complaints

- Pervasive low mood
- Decreased social interaction
- Forgetful of recent events and information
- Lack of interest in previously pleasurable activities
- Bleak ideas about future

Decreased sleep and appetite

- Not going for work

History of presenting illness

Mr G was reportedly asymptomatic and functioning well till four months ago when he had taken a large sum of money as a loan for the construction of his house. He had started the construction of his house with great enthusiasm. However, the realization of the large sum of money to be repaid resulted in him becoming very dull with low mood. He would often not respond to circumstances or others and appeared very preoccupied. He interaction with his family members and colleagues gradually declined and he began to spend more and more time alone. He was unable to take initiative to do any activity that he found to be pleasurable earlier. He often expressed that there was no point in living and that he was helpless. However, he never expressed any suicidal idea nor did he make any plans or attempts. The severity of these symptoms remained constant and did not change over the course of the day. He began to stay away from work and remained home and began to show little interest in going to work again. Gradually, he began to have difficulty in concentrating on conversations and events. He was unable to recall details of recent events and details in conversations and often did not make any effort to recall them. His motor activity decreased and he preferred to remain seated in his chair or lie down on his bed throughout the day. His sleep declined and he had difficulty in going to bed. His appetite and food intake decreased and he lost a significant amount of weight over the past four months. His self-care

declined and he required prompts to engage in his activities of daily living. His construction of the house stood still as he began to look at this in a pessimistic manner. There was history of an injury to his head which resulted in loss of consciousness for a short duration. However, there was no history suggestive of any ear bleed, seizures and imaging revealed no structural abnormalities.

There was no history suggestive of any substance dependence, first rank symptoms, manic symptoms, obsessive compulsive symptoms, phobia or panic attacks.

There was no history suggestive of any disorientation, incontinence, apraxia, aphasia or agnosia.

Treatment history

He has had a trial of Escitalopram up to 20mg/day which was augmented with Risperidone 1mg for four months. In view of poor response, the antidepressant was changed to Sertraline which was titrated to a dose of 125mg/day. Psychotherapy was also provided as an adjunct.

Birth and Developmental history

There was no reliable informant to elicit his birth and developmental history.

Family history

He was born of a non-consanguineous marriage. There was no family history of psychiatric illness, suicide, alcohol or drug use, personality problems or epilepsy. He currently stays with his wife, his two sons and their respective families.

Educational and Occupational history

Mr G has studied up to 8th Grade. He was an average student at school and did not have any issues with his teachers or peers. He had to drop out of school due to financial constraints.

He had always been involved in agriculture and was successful in his agricultural business until the onset of the illness four months back.

Sexual History

Mr G was heterosexual in his orientation. He complained of decreased libido for the past six months. There was no history suggestive of dysfunction or risk behaviour.

Marital History

Mr. G was married to Mrs. S, who was a home maker. They have been married for the past twenty-two years. He described his marital life as satisfactory and sexual adjustment as satisfactory as well.

Premorbid personality

Mr G was reported to be responsible and had high religious and moral standards. He was social, cheerful, outgoing and was involved in several political activities.

Medical History

He had Type II Diabetes Mellitus and was on treatment with oral hypoglycaemic medications. He was also under treatment for dyslipidaemia.

Physical examination

His vitals were stable.

BMI: 23.32

Cardiovascular, respiratory and abdominal examination was within normal limits

Central nervous system examination:

Higher function – MMSE 21/30

Cranial nerves - Normal

Motor system

Bulk - Normal bilaterally

Tone - Normal tone bilaterally

Power - Grade 5 power bilaterally

No involuntary movements

Sensory system

Crude touch, Pain, Temperature - Normal bilaterally

Light touch, Vibration and Joint position sense - Normal bilaterally

Reflexes

Superficial abdominal reflex - Present all four quadrants

Plantar reflex	- Flexor bilaterally
Deep tendon reflexes	- 2+ bilaterally
Cerebellar functions	- Normal
Gait	- Normal
Meningeal signs	- Absent
Skull and spine	- Normal

Mental status examination

He was moderately built and adequately nourished. He was well kempt and maintained good eye contact. Rapport was difficult to establish. He was alert and lucid. He was able to comprehend simple and complex instructions. He maintained an erect posture and his psychomotor activity was retarded. There were no fluctuations in his motor activity. His reactive movements were diminished with appropriate, purposeful and smoothly coordinated goal directed movements. There were no non-adaptive movements. His speech was hesitant with good comprehension. It was fluent but slow in reaction time and speed, laconic in productivity and monotonous in pitch but was relevant throughout the interview. His mood was depressed. There was decreased range and reactivity of affect but it was appropriate and congruent with minimal somatic accompaniments. He denied suicidal ideations. There were no abnormalities in his form and stream of thought. His content of thought revealed depressive cognitions of helplessness and hopelessness. There were no abnormalities in the form and stream of thought. He was oriented to time, place and person. His recent, remote and immediate memory was intact. His attention was difficult to arouse and sustain and

his concentration was impaired. His intelligence was average. His personal judgement was impaired but his social and test judgement were intact. He had intellectual insight into his illness, with him being aware of his symptoms and willing to take treatment.

Differential diagnosis

- Severe Depression without psychotic features
- Pseudo dementia
- Dementia of Alzheimer's disease with early onset

Aims for neuropsychological testing

- To assess cognitive profile of Mr. G
- To correlate findings to clinical profile
- Plan further management according to cognitive functioning

Tests Administered and Rationale

- **NIMHANS Neuropsychology Battery (2004)**
- **Rationale:** The battery was developed by Shobini Rao et al. This assesses a subject's performance across various domains of neuropsychological functions. It has been validated to suit the Indian adult population.

Behavioural Observation:

He was initially cooperative for the assessment but had difficulty in sustaining his attention over the course of the assessment. Therefore, the assessment had to be held over multiple sessions. Although, there was no active resistance in doing the assessment, he required frequent reassurances and encouragement to complete and persist with the assessment. He tended to give up easily and despite repeated encouragement, did not complete a few subtests or did not perform them with interest. He was able to comprehend the instructions well. His verbal communication was adequate. There was no performance anxiety observed.

TEST RESULTS

NIMHANS Neuropsychological Battery

Mental speed

On the digit symbol substitution test, the total time taken to complete was 522s which is below the 3rd percentile, indicative of significant impairment in mental speed.

Sustained attention

On the digit vigilance test, he was not cooperative to complete the test as his visual impairment interfered with his performance.

Focussed Attention

On the Colour Trails Test 1, the total time taken to complete was 222s which is below the 5th percentile and the total time taken to complete Colour Trails Test 2 was 631s

which is also below the 3rd percentile. Both are indicative of significant impairment in focussed attention.

Divided Attention

On the Triads Test, the total errors were 14, which is at the 3rd percentile, indicative of significant impairment in his ability to divide his attention between two tasks requiring different sensory modalities. He was able to focus his attention on only one of the tasks he was instructed to do.

Executive functions

- **Phonemic fluency**

  Phonemic fluency was assessed by the Controlled Oral Word Association Test (COWAT). On the COWAT, the average number of new words generated was 2.34 which is below the 5th percentile and is indicative of significant impairment in phonemic fluency.

- **Categorical fluency**

  Was assessed by the Animal Names Test. The total new words generated was 8, which is at the 5th percentile, indicative of significant impairment in categorical fluency.

  Better performance in the Animal Names Test than in the COWAT is suggestive of impaired verbal executive skills.

- **Working memory**

  Working Memory was assessed using the Verbal N back Test. The number of 1 back hits was 9 and errors was 6 which fall below the 25th and at the 3rd percentiles respectively. The number of 2 back hits was 7 and errors was 8, which fall below the 30th and at the 11th percentiles respectively. This is indicative of significant impairment of working memory.

- **Planning**

  Planning was assessed by the Tower of London Test. The total number of problems solved in the minimum number of moves is 5, which is at the 5th percentile. The mean time taken, the mean moves and the number of problems with minimal moves are as follows,

No of moves	Time taken	Percentile	Mean moves	Percentile	No of prob with minimal moves
2 moves	10s	**26**th	2	**100**th	2
3 moves	25s	**19**th	2	**100**th	3
4 moves	45s	**16**th	6	**53**rd	0
5 moves	40	**24**st	9	**29**th	0

The fluctuations in scores and the time taken to complete the tests indicate impairment in attention more than an impairment in problem solving per se.

Verbal Learning and Memory

On the auditory verbal and learning test, the total number of correct words recalled is 19, which is below the 5th percentile; the immediate recall and delayed recalls are at 2 and 3 words which are both below 5th percentile. The long term percentage retention is 75%. The number of hits in the recognition trial is 11 which is at the 5th percentile. This indicates the presence of deficits in verbal learning and memory. His recognition also is impaired. This is indicative of deficits in both recall and storage of information.

Visuo - spatial construction and visual learning and memory.

On the ROCF, the copying score is 18, which is below the 5th percentile. The immediate recall score is 3 which is below the 5th percentile and the delayed recall is impaired as well (<5th percentile). This indicates significant impairment in visuo-constructive ability and visual memory.

Impression

Although the neuropsychological assessment revealed significant deficits in all domains of functioning, it was found to be out of keeping with his day to day functioning and did not correlate to imaging of his brain which revealed no structural abnormalities. Hence, the deficits were attributed to the presence of depressive symptoms.

Management

As organicity was ruled out and there was clear evidence of depressive symptoms clinically, he was started on Tab. Escitalopram up to 20 mg per day. As he showed minimal improvement, another anti-depressant trial was considered and he was started on Tab. Sertraline 150 mg per day and later augmented with Risperidone 1 mg. Cognitive behaviour Therapy was initiated to address his depressive cognitions. Cognitive distortions were identified and he was taught to reframe his thoughts cognitively and develop more realistic thoughts and beliefs. Gradually, his depressive symptoms subsided and with that, his complaints about his memory deficits also stopped.

CASE RECORD 2: IQ Assessment

Name : Master MIP

Age : 14 years and 6 months

Sex : Male

Education : 8th grade

Informant : Father

Reliability : Reliable and adequate

Presenting complaints

Poor academic performance, in all subjects

Poor attention span

Adamant behaviour

Rigid routine

Poor socialization with his peer group

Hyperactivity

Disruptive behavior when demands are not met

Duration of illness – since childhood, worsening with promotion to higher classes

Mode of onset – Insidious

Precipitating factors – Nil

History of presenting complaints

Master MIP was brought with history of poor academic performance which was worsening with promotion to higher classes. Since childhood he has been observed to have stereotypies in the form of repeatedly asking his mother questions and seeking reassuarance from her for the same and becoming aggressive when family started ignoring his queries. He has been described to have narrowed interests and behaviours. He always would engage in solitary play and had minimal interaction with other children in his school. With progressive promotion to higher grades, he had difficulty in coping with the academics, and had to be promoted with grace marks. Currently he is in 8th grade and has significant difficulty with all subjects. There was no history suggestive of psychotic syndrome, mood syndrome or phobia. There was no history suggestive of substance use. There is no history suggestive of ADHD.

Past history and Medical history

There is past history of Obsessive Compulsive Disorder which was treated with Tab.Sertraline 50mg and Tab.Aripiprazole 5mg which was gradually tapered and is currently in remission.

Birth and development history

Prenatal: Planned pregnancy with Pregnancy Induced Hypertension in mother during second trimester.

Perinatal: Full term, normal vaginal delivery, at hospital with newborn weighing 2.90kg . Birth cry was present.

Postnatal: Breast fed up to 1 year and 8 months of age. Immunized for age. No history of neonatal complications.

Developmental history: History of delayed language milestones with motor milestones being attained age appropriately

Motor milestone - Head control by 3 months

- Sitting unassisted by 6 months
- Standing unassisted by 9 months
- Walking without support by 1 year .
- Riding a tricycle by 3 years

Fine motor milestones - Radial grasp by 5 months

- Mouthing of objects by 5 months
- Transferring objects from one hand to other hand by 7 months
- Pincer grasp by 9 months

Social maturity - Responds to name by 1 year

- Independent in basic activities of daily living
- Requires assistance for instrument activities of daily living

Language – Bisyllables by the age of 21 months

First word by 1 year

2 word phrases by 4 years

Comprehension of simple questions by 7 years

Currently speaks in sentences,pronunciation of certain words are not coherent

He is independent in his basic activities of daily living.

Emotional development and temperament

He has been described to be an introverted child, indulging in solitary play and having minimal social interaction. He liked watching specific TV shows. There is history to suggest assaultive and aggressive behavior. History is also suggestive of behavioral problems.

School history

Currently studying in 8th standard. Performance has been below average and currently has difficulty coping with all subjects.

Family history

There is no family history of Dysthymia and obsessive compulsive disorder in mother. There is no family history of any other neuropsychiatric morbidity.

Physical examination

His vitals were within normal limits. His systemic examinations were within normal limits.

Mental status examination

He was moderately built and was well kempt. He was co-operative and alert during interview but was easily distractible. His attention could be easily aroused but not sustained for a reasonable period of time. He was calm, responding only when asked questions and maintaining poor eye contact. Primary mental functions were intact. Speech was normal in tone, rate and increased in reaction time. He denied any perceptual abnormality. His mood was euthymic.There was no stranger anxiety or separation anxiety.He did not show any stereotypies. His intelligence appeared compromised as suggested by impairment in tests of comprehension and general knowledge. He had no insight.

Provisional diagnosis

Moderate Intellectual disability with significant behavioral problems

Autism Spectrum Disorder

Obsessive Compulsive Disorder – in remission

Aims of psychological testing

As history was suggestive of poor scholastic performance and, mental status examination revealed impairment in tests of comprehension and general knowledge.

Tests administered

1. Binet-Kamat Test of general mental abilities
2. Vineland Social Maturity Scale (VSMS)

Rationale for the tests

BKT was used to assess intelligence as it is standardized in the Indian population

VSMS was used to assess the social adaptation and social age

Behavioral observations

Master MIP was co-operative and willing for the tests. He was attentive but was easily distracted and required frequent breaks during the tests. He maintained poor eye contact and was fidgeting in the chair.

Test findings

1. **Binet- Kamat Test**

The basal age was found be 4 years and the terminal age was 6 years.

Mental age – 5 years

Chronological age – 14 years

The IQ of Master MIP based on the Binet-Kamat test was 36.

2. **VSMS**

The social age of Master ED was found to be 6.75 years. The profile of age levels across the functions was as follows:

Self-help general	3.15 years
Self-help dressing	8.45 years
Self-help eating	8.05 years
Communication	3.15 years
Self-direction	5.83 years
Socialization	5.13 years
Locomotion	4.70years
Occupation	8.53 years

Impression

The IQ according to the Binet- Kamat test was suggestive of Moderate intellectual disability.

Management

1. The parents were educated about his diagnosis and its implications. They were allowed to ventilate and support was provided. Their doubts were clarified.
2. Master MIP and his parents were taught the importance of maintaining Activities of Daily Living Chart and, following a reward system. The parents were also taught about behavioral management techniques and differentially rewarding skill behavior and problem behavior.
3. The need to encourage other domains of his abilities like creative aspects of music and drawing was addressed.
4. Skills training through special education strategies were done.
5. Higher order self care skills training was done.

CASE RECORD 3: Diagnostic Clarification

Name	: Mr. TN
Age	: 25 years
Sex	: Male
Marital status	: Unmarried
Religion	: Hindu
Language	: Kannada
Education	: MBBS
Occupation	: Student
Socio-economic status	: Upper Middle
Residence	: Semi-urban
Informant	: Mr. TN and his parents

Presenting complaints

Non pervasive low mood	Eight years
Decreased self-esteem	Eight years
Anxiety	Eight years
Decreased sleep	Eight years

Academic decline	Eight years

History of presenting illness

Mr TN was reported to have been doing well till eight years ago. He was described as an academically bright individual who had always been one of the top students in his school. During schooling he was noted to be motivated and was focussed on obtaining a seat for his medical education. He earned a seat for his medical studies in a prestigious institution. However, following his admission into the college, he began experience feelings of loneliness even when there were other students around him. He began to have difficulties in his academic performance and started comparing himself with his peers. He began to feel that his peers were performing better than him academically. Mr.TN had always regarded himself as a high achiever and was unable to come to terms with the fact that at some point his peers were performing better than him. Secondary to these feelings, he began have briefs episodes of tearfulness. He also noticed that his peers were unable to adjust with him with regard to his need to do everything in a particular manner itself. He also found that he was unable to be flexible with the complex demands of his academic venture and this created in him a constant sense of anxiety and uneasiness. Gradually, his academic performance declined and he began to have interpersonal issues with his peers. He began to have difficulty in concentrating on his studies due to his preoccupation with his inability to achieve his goals. He began to feel low in mood most of the day but was initially able to distract himself without it causing significant distress and impairment. Gradually, he was unable to distract himself and his appetite decreased and his sleep was disturbed. He began to have

difficulty in initiating sleep and would often toss and turn in his bed till late at night. Although he was able to attend his classes regularly, he was unable to complete his assignments or concentrate on his studies. He had consulted with a Psychiatrist and was prescribed medications. While on the medications, he reported of an increase in his confidence levels, decrease in his need for sleep, increase in speech productivity and increase in his appetite. He also reported of thoughts racing and that changes in his behaviour were noted by his friends. These changes lasted for a duration of two weeks and subsided spontaneously. He has had no other similar episode following that. Since then, he reports predominantly of low mood, anxiety, ruminations secondary to interpersonal issues with peers and family members.

There is no history suggestive of organicity, substance dependence, first rank symptoms, melancholic symptoms, mania or hypomania, phobia or panic attacks.

There was no history of conduct disorder or pervasive developmental disorder.

Treatment history

He had been treated with Sodium Valproate (up to 500mg per day), Lamotrigine (up to 50 mg per day) and Sertraline (up to 200mg per day). At the time of his index visit to the hospital, he was on a combination of Lithium and Fluvoxamine.

Family history

There is family history suggestive of low frustration tolerance in his father. There is also history suggestive of marital discord between his parents. There is history of completed suicide in a second and a third degree relative on the paternal side.

Developmental history

The antenatal period was supervised and uneventful. Birth was full term normal vaginal delivery with no birth asphyxia or neonatal seizure. Postnatal period was uneventful. His developmental milestones were reported to be normal. There is history suggestive of tic disorder in childhood and probable acute flaccid paralysis of lower limbs at eight years of age.

Educational history

Mr. TN has completed his MBBS Degree from a Government medical college and completed his internship from the same institute. His academic performance was above average while in school. He reports to have had interpersonal problems with some of his peers and his teachers.

Sexual history

He had male gender identity and heterosexual orientation. He engaged in masturbatory practice and did not report any guilt regarding the same. He did not have aby misconceptions regarding masturbation. He denied any high risk sexual behaviour.

Marital history

He was unmarried.

Premorbid personality

He was reported to be rigid and have inflexible patterns of cognition and behaviour, poor frustration tolerance, high rejection sensitivity and persistent interpersonal relationship difficulties.

Physical examination

His vitals were stable and his systemic examinations were within normal limits. He was moderately built with a BMI of 22.6

Mental status examination

He was a moderately built and nourished individual. He was well kempt and maintained good eye contact. Rapport could be established easily. He was alert and lucid. He was able to comprehend simple and complex instructions. His speech was spontaneous with good comprehension. It was fluent, rapid, garrulous with normal fluctuations in pitch, normal reaction time and relevant throughout the interview. His mood was dysphoric mostly with occasional irritability. There was normal range and reactivity of affect. He denied suicidal ideations. There were no abnormalities in his form and stream of thought. His content of thought revealed depressive cognitions and low self-esteem. No thought alienation phenomena or perceptual abnormalities were present. He was oriented to time, place and person. His recent, remote and immediate memory was intact. His attention could be aroused and sustained. His intelligence was average. His test judgement was intact and his social judgement was impaired. He had partial insight into his problems.

Differential diagnosis

DYSTHYMIA

MIXED PERSONALITY DISORDER

Aim for psychometry

To clarify symptomatology, psychopathology and diagnosis

Tests administered and their rationale

1. **Rorschach Inkblot Test**

   Rationale: The Rorschach Inkblot Test provides an understanding of structure of the personality, affectional needs and ego strength. It also indicates degree of psychopathology.

2. **Sack's Sentence Completion Test**

   Rationale: Sacks Sentence Completion Test is a projective test developed by Dr Sacks and Dr Levy. It consists of 60 partially completed sentence to which respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception.

Behavioural observation

Mr. TN was cooperative during the assessment. He was observed to be anxious initially, making poor eye contact, frequently looking down, and sitting in an erect posture. However, rapport was easily established. He was able to comprehend the

instructions easily and was able to communicate appropriately. No hallucinatory behaviour or distractibility could be observed.

Test findings:

Rorschach Inkblot Test

The Rorschach protocol indicates average productivity with slow mentation. The protocol indicates a suppression of impulsivity implying the presence of conflicts, inner tension and excessive control. He tends to be inhibited and represses his impulses through compulsive emphasis on organization and achievement. He tends to be affected by emotional impact from the environment. W cut responses indicate an over critical and perfectionistic nature. He tends to have a high level of aspiration without the necessary creative potential to achieve it. There are adequate number of popular responses indicating adequate ties with reality.

Sentence Completion Test

In the Sentence Completion Test (SCT), he feels that his relationship with his mother is conflicted. While he feels that his mother shows a lot of concern for him, he does not feel the same towards her. He feels that she tends to ignore his negatives and only praise his positive qualities. He feels that his relationship with his mother will not improve and does not want it to improve. He expresses a desire that his father was someone important and that he did not have a psychiatric illness. He feels that his family tend to have high expectations of him. The SCT indicates a strong desire to be able to speak to the opposite gender but his inhibitions prevent him from doing so. There is significant

regret regarding various aspects of his past. Low self-esteem is seen from a strong desire to be recognized by others but with constant self-depreciation of his capacities. His attitude towards the future appears ambivalent. While he expresses a strong desire to be successful, he also feels that his future appears bleak. There are conflicts in his attitude towards interpersonal relationships. He tends to feel dominated by others and is therefore, prefers people who are passive. He feels that he lacks conviction and fears that he may not be able to handle leadership roles. His attitude towards heterosexual relationships appear ambivalent. While he expresses a desire to be in a relationship, he feels he will be unable to handle the responsibilities that come along with that.

NEO FFI

In the NEO FFI 3, he scored very high on neuroticism, very low in extraversion, low in openness, low in agreeableness and average in conscientiousness. He tends to be emotionally reactive and copes poorly with stress. Poor emotional regulation may interfere with his ability to think clearly, make decisions and cope effectively with stress. He tends to be uncomfortable around others, is sensitive to criticism and prone to feelings of inferiority. He tends to be formal, reserved and prefers to avoid social stimulation. He tends to have a narrow range of interests. He tends to be sceptical and has assumes that others are dishonest. He is often guarded in expressing his true intentions or feelings. He tends to be self-centred and is reluctant to get involved in other people's problems.

Management

As clinical interviews and psychological assessment did not reveal the presence of psychotic or mood symptoms, his mood stabilizers were gradually tapered off. Anti-depressant was commenced and maintained at a low dose. Management was focused on non-pharmacological methods. He was educated about cognitive behavioural therapy and the rationale for it. He was educated about negative automatic thoughts and was taught to identify them with the help of thought record diary and Socratic questioning. He was taught to reframe his negative thoughts about self and others with the help of cognitive strategies. Resistance when encountered was reflected to him and the need for change in maladaptive patterns were mutually acknowledged. He was enrolled in occupational therapy and an activity schedule was initiated to facilitate a structured daily routine and opportunities for social interaction. His mother was educated about his condition and management options. At the time of discharge, he was able to follow the activity schedule, keep a thought diary, identify frequent cognitive errors and generate adaptive strategies to manage them.

CASE RECORD 4: Diagnostic Clarification

Name	: Ms. SM
Age	: 19 years
Sex	: Female
Marital status	: Unmarried
Religion	: Christian
Language	: Hindi, Bengali
Education	: GNM nursing 1st year
Occupation	: Student
Socio-economic status	: Middle
Residence	: Rural
Informant	: Ms. SM and her parents

Presenting complaints

Belief that she will be persecuted	Five months
Belief that she is being controlled	Five months
Intermittently hearing unknown voices	Five months

Intermittent episodes of posturing of neck	Five months
Crying spells	Five months
Decreased sleep	Five months
Attempts of Deliberate Self Harm	Two attempts

History of presenting illness

Ms.SM presents with history of symptoms for a duration of five months.She describes her symptom as seeing a vision of a lady hanging from a noose,she describes the lady as someone she has never seen before.She further describes the lady to smile at her and she would feel like strangulating herself.She reports that she knew that she shouldn't kill herself but as if she had no control over herself and was being controlled.During this episodes as per her parents report she was noted to be agitated,screaming and attempted to strangle herself.During this episode she is also reported to have tried to run away from her home.Subsequently she received magico-religious treatment and after three to four days her symptoms subsided.Since then she was doing well and hence joined a hostel to pursue her GNM course in nursing.While in the hostel these episodes continued and she consequently had three similar episodes.Prior to seeing this image she describes a subjective sensation of uneasiness and feels like crying.Each episode lasts for around 15 minutes,subsides spontaneously and she is able to resume her routine.She denied any stressors at home or hostel.

There is no history suggestive of any seizures or head injury

There is no history suggestive of substance dependence

There is no history suggestive of first rank symptoms

There was no history of depressive syndrome or mania or hypomania.

There was no history of phobia or panic attacks.

There was no history of conduct disorder or pervasive developmental disorder.

Treatment History

She had received magico-religious treatment for her problems before.

Family history

She has an older sister who is 20 years of age and two younger sisters. There is history of similar illness in her mother and younger sister.There is also history of seizures in elder sister

Developmental history

The antenatal period was supervised and uneventful. Birth was full term normal vaginal delivery with no birth asphyxia or neonatal seizure. Postnatal period was uneventful. Her developmental milestones were reported to be normal.

Educational history

Ms.SM has completed her 12th grade and is currently pursuing her bachelor's degree in General Nursing. She has currently completed her first semester but was unable to write her second semester exams due to her current symptoms. Ms SM is reported to be an average student in school. She has had good relations with her teachers and also reports to have many friends.

Sexual history

She had female gender identity and heterosexual orientation. She did not engage in masturbation or in any high risk sexual behaviour.

Marital history

She was unmarried.

Premorbid personality

She was reported to be a quiet,calm and hardworking individual. She was sociable and interacred freely with her friends and family members. She had high religious and moral standards. She was also reported to be an anxious individual especially when it came to achieving new targets or setting goals.

Physical examination

Her vitals were stable and her systemic examinations were within normal limits.

Mental Status Examination

Ms.SM was a thinly built ,adequately kempt individual .Initially she was hesitant and eyecontact was fleeting but over subsequent examinations rapport could be established and she was able to maintain adequate eye contact.No non adaptive movements were noted.Speech was spontaneous with good comprehension.Her mood was found to be euthymic.Examination of thought revealed normal form and stream of thought.She was guarded in the beginning but progressively her cooperation improved.Her speech was hesitant,with normal productivity and good comprehension.Her mood was assessed to be irritable with affective flattening and restricted range and reactivity.Examination of thought revealed normal form and stream of thought.Content of thought revealed bizarre descriptions of the images she saw.No depressive cognitions were noted.Initially no stressors could be elicited but eventually stressors with regard to how ger father would fund her education,inability to cope with her academic requirements were noted.She reported episodic ,transient perceptual abnormalities in the form of being able to see a lady hanging by a noose.Her higher mental functions were intact.Reality testing and judgement were intact.She had partial insight of grade 3.

Differential diagnosis

Dissosciative Disorder

Transient Psychosis

Epilepsy

Aim for psychometry

To clarify symptomatology, psychopathology and diagnosis

Tests administered and Rationale

1. **Sack's Sentence Completion Test**

   Rationale: Sacks Sentence Completion Test is a projective test developed by Dr Sacks and Dr Levy. It consists of 60 partially completed sentence to which respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception.

2. **Thematic Apperception Test**

Rationale: Thematic Apperception Test is a projective measure intended to evaluate a person's patterns of thought, attitudes, observational capacity, and emotional responses to ambiguous test materials. It elicits information about a person's view of the world and his attitudes toward the self and others

3.NEO Five Factor Inventory

Rationale: The NEO-FFI is a 60-item test. It provides a quick, reliable and accurate measure of the five domains of personality and is particularly useful when time is limited and when global information on personality is sufficient.

4.International Personality Disorder Examination (IPDE) ICD-10

Rationale: The IPDE is a semi-structured clinical interview that provides a means of arriving at the diagnosis of major categories of personality disorders and of assessing personality traits in a standardized and reliable way. The screening questionnaire is a tool used to eliminate individuals who are unlikely to have a personality disorder.

Behavioural observation

Ms.SM was observed to be cooperative during the interviews. She was observed to be anxious initially, making poor eye contact frequently looking down, and sitting in an erect posture. Rapport was easily established. She was able comprehend the instructions easily and was able to communicate appropriately. No hallucinatory behaviour or distractibility could be observed.

Test Findings

1. **Sack's sentence completion test**

   She has a good relationship with her mother and values her care and concern towards her. She expressed significant guilt that her symptoms were causing distress to her mother. Areas of conflict were seen in her relationship towards her father.She viewed him as an individual who ignored her and her wishes.Though she had problems in her family, she viewed her family as a close unit and considered her family as a model one.While she was proud of her academic achievements and ability, she was concerned about her inability to manage stressful situations.She expressed high religious values and fear of ghosts.She views her past as a mixed state of happiness and sadness and has some regret that she could have been more hard working with regard to her academics. Her attitude towards the future is optimistic. She hopes that she will able to manage

his symptoms and will be able to achieve the goals that she has set for herself in life. Her attitude towards women is predominantly neutral. Her attitude towards heterosexual relationships is negative and often felt that it was unnecessary.

2. **Thematic Apperception Test**

In the TAT, the stories are detailed in their description and well structured. Her stories portray a protagonist who found himself/herself in unfavourable situations ,who usually did not take favours from others but always strived against the odds and overcome them. The stories also showed a deep sense of affection towards the family members. The heroes of the stories are portrayed as hard working and sincere in their tasks. No stories suggestive of incomplete conflict resThe dominant needs that are seen in most of the stories are need for counteraction and autonomy. The dominant press seen in the stories are obstacles, and environment. The major emotions and feelings manifested in the stories are sadness, determination and perseveration. Predominant feelings of fear towards loneliness darkness and uncertainity was noted.Elaboration of feelings towards abandonment and isolation were seen.Conflicts between autonomy and deference are seen through most of the stories.

3.NEO FFI

In the NEO FFI, she scored very high on neuroticism, low in extraversion, low in openness, very low in agreeableness and conscientiousness. She tends to emotionally reactive and copes poorly with stress. She was noted to have poor emotional regulation which made it difficult for her to cope effectively with stress. She was noted to hold unconventional beliefs. She tended to place others above herself. She gave a lot of importance to others opinion about herself. She was noted to be very concerned about others feelings and often held herself responsible for their happiness.She denied to have a creative side to herself and was unwilling to try new things.

4. International personality disorder examination (IPDE) ICD 10

The questionnaire revealed predominant anxious personality traits, with her acting often on an emotional mind and finding it difficult to cope with her tasks. Also a few anankastic personality traits were evident. She considers herself as a likeable person with close friends and several lasting relationships. There were no evident indicators of a psychosis or pervasive mood syndrome.

Management

During the initial part of the admission she was started on Tab.Risperidone in view of perceptional abnormalities.Following the ward observations,antipsychotics were stopped inorder to oberve her symptoms in the ward.A neurology consult was obtained to evaluate for seizure

phenomena.However,her neurological examination and her EEG did not show any seizure activity.Stressors emerged predominantly regarding conflicts with her father,financial status of her family and apprehensions as to wether she will be able to cope with her academics.As rapport was established she was able to discuss her stressors.Appropriate coping methods and relaxation techniques were taught to her.She was able to practice the techniques while in the ward and reported subjective feeling of feeling better.She was encouraged to attend Occupational Therapy,where she was exposed to academic tasks in a graded manner.At the time of discharge she reported to be feeling confident to continue her academic pursuits.

Family members were allowed to ventilate their distress and support was provided to them. They were educated about the nature of the illness, its course and prognosis. The treatment options were discussed and the important of non-

Summary of test findings

The assessment was suggestive of predominant anxious traits and a tendency to repress her emotions and high moral standards.They revealed high hopes for her pharmacological management was emphasized to sustain her improvement. They were able to understand the psychological model of the illness.

CASE RECORD 5: Personality Assessment

Name	: Mr N
Age	: 21 years
Sex	: Male
Marital status	: Unmarried
Religion	: Hindu
Language	: Tamil and English
Education	: MBBS
Occupation	: Student
Socio-economic status	: Middle socio-economic status
Residence	: Urban
Informant	: Mr N and his parents

Presenting complains

Decreased concentration	Five years
Repetitive need to void	Five years
Anxiety	Five years
Avoiding social situations	Five years

Academic decline Five years

History of presenting illness

Mr N was reportedly functioning well till five years ago when he completed his 12th grade exams. As the marks he obtained could not qualify him for seat in a Medical College by merit, he was distressed but was able to cope well. However, as his father had a strong ambition that Mr N should become a doctor, he reportedly was able to obtain a management seat in a college in Karnataka which required him to mortgage their house. Following admission into the college, he reportedly had difficulty in coping with the culture of the students in the college. He began to feel inferior to them as they were able to speak in fluent English and were able to spend a lot of money on recreation unlike him. He had only a few friends who were from a similar socioeconomic status and preferred to avoid mingling with others. However, his academic performance during his first year did not show any decline.

From his second year in college, he began to feel anxious while interacting with his peers – especially those of the opposite gender, his teachers and when asked questions in class. He began to experience palpitations, tremors and was unable to verbalize even answers he knew off. He also began to experience frequent need to void in situations he considered stressful such as during classes and examinations resulting in significant preoccupation with location of restrooms, duration and time of class intervals and anticipatory anxiety. Attempts to resist it have been unsuccessful and resulted in more anxiety. He underwent a consultation with an Urologist and evaluation did not reveal any organic cause of his frequent need to void. Gradually, he began to avoid attending

classes and he began to spend most of his time in the hostel leading to a lack of attendance and hence being deemed ineligible to write his examinations. He also began to have difficulty in concentrating on his studies and had thoughts of quitting his course. However, due to the huge sum of money involved in his admission, he was in conflict about expressing this to his parents as he was afraid of disappointing his father. Secondary to his dysphoria and anxiety, he began to use nicotine, cannabis and alcohol along with his friends initially and later by himself. The pattern of his cannabis and alcohol use was not in a dependence pattern and he used them based on their availability which ranged from twice a week to once a month. He did not report of any craving for either cannabis or alcohol. His last use of cannabis and alcohol was one month ago. However, he continued to smoke nicotine in the form of cigarettes every day and had craving for it when he made attempts to quit. Due to his anxiety and his lifestyle changes, he began to feel guilt and has made three suicidal gestures of low intentionality and lethality over the last one year.

There was no history suggestive of head injury, seizures, first rank symptoms, pervasive mood syndrome or phobia or panic attacks.

Treatment history

He had been diagnosed with Obsessive Compulsive Disorder (OCD) in the past and has had a trial of Mirtazapine with which no significant improvement was reported. His index visit here in MHC was on 22.03.2017, when he was on Sertraline 50mg/ day, Dothiepin 25mg/ day, Propranolol 40 mg/ day and Clonazepam 1mg/ day. In view of

probable diagnosis of OCD, Sertraline dose was increased to 100mg/ day and other medications were tapered and stopped.

Family history

He is the second child born to his parents of a non-consanguineous union. He lives in a nuclear family, and has an elder sister. His father is an administrative officer in a hospital and his mother is a nursing superintendent. His sister is a doctor and is married.

There is family history suggestive of probable anxiety disorder in his parents and dementia in late paternal grandfather.

Developmental history

The antenatal period was supervised and uneventful. His delivery was full term normal vaginal and there was no birth asphyxia or neonatal seizure. His postnatal period was uneventful. His developmental milestones were reported to be normal.

Educational history

He was pursuing the First year of his MBBS course and his academic performance had shown gradual decline.

Sexual history

He had a male gender identity and was heterosexual in orientation. He reported having a single partner. There was no history of high risk behaviour. He had guilt regarding masturbation and denied any sexual dysfunction.

Marital history

He was unmarried

Premorbid personality

He was described to be introverted and anxious. He was reported to cope poorly with distress and had a tendency to worry excessive. However, he was also reported to be sceptical and make fun of other people. He was not very religious and had a low moral standard. There is history suggestive of occasional alcohol and cannabis use and nicotine use in dependence pattern.

Physical examination

His vitals were stable and his systemic examinations were within normal limits.

Mental status examination

He was moderately built and appropriately groomed. Rapport could be established with him. He maintained eye contact. There were no abnormal motor movements. His speech was relevant and coherent. His mood was anxious with normal range and reactivity. He denied suicidal ideations. There were no abnormalities in the form and stream of thought. His content of thought revealed worries about his frequent visits to restroom and academic difficulties. There were no perceptual abnormalities. He was oriented to time, place and person. His memory was intact. His intelligence was average and his insight into his condition was partial.

Provisional diagnosis

- Anxious Avoidant Personality Disorder
- Benzodiazepine Dependence syndrome – continuous use
- Nicotine dependence syndrome - continuous use

Aim for psychometry

To identify and explore significant personality factors influencing the psychopathology

Tests administered and the rationale

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towards a personal experience of life. It helps to elicit ideas of self-perception.

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3. **NEO Five Factor Inventory**

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Behavioural observation

During the entire period of assessment, he was cooperative. Rapport could be established easily. He was sitting in an erect posture and relaxed manner throughout the interview. He could comprehend the instructions and paid adequate attention. He appeared well motivated for the assessment.

Test Finding

1. **Sack's sentence completion test**

In the SCT, there are conflicts observed in the areas of his relationship with his parents, self-concept and interpersonal relationships. Although he feels that his father loves him, he feels that he is punitive and often takes decisions without considering his opinion. He feels that his father is more focused on his career than himself. He has a closer relationship with his mother and feels more attached to her. However, he feels that she tends to worry excessively over trivial issues and that it affects him. He appears to have low self-esteem and lacks confidence in his ability to face adverse situations. He has a tendency to give up rather than attempt to cope with them. He has a pessimistic view of the future. While his attitude in his interpersonal relations towards his superiors is that of submission, he tends to have a dominant attitude towards subordinates and wants to be respected by them.

2. Thematic Apperception Test

In the TAT, his stories are detailed and descriptive. Most of the stories are well organized in their structure. He identifies himself as the hero in most of the stories. Most the heroes have been portrayed as helpless indicating that although there is a need for achievement, the person is unsure of her own abilities. The presses identified in the stories are both external and internal. The major external presses include societal and parental pressure and socioeconomic status; the internal presses include feelings of inferiority, fear of rejection and divide between ambition and performance. The dominant

needs across the stories are need for achievement, need for dominance, need for nurturance and need for autonomy. The stories reveal conflicts between need for achievement and autonomy versus need for deference; need for dominance versus need for affection. Emotions and feelings seen across the stories include anger, resentment, inferiority and shame.

3. NEO FFI

In NEO FFI, he scored very high on neuroticism, low on extraversion, average on openness, low on agreeableness and low on conscientiousness. He tends to worry more and is generally apprehensive. His emotions tend to disrupt and interfere with his general adaptation. He tends to have poor control over his impulses and copes poorly with stress. He tends to be reserved and under assertive initially with people. However, as there is also a tendency to be dominant with people whom he considers as weaker than him and dependent on people whom he feels are superior to him. He maintains a balance between curiosity and sticking with the routine in his attitude. He tends to have a narrow range of interests and this might also influence his limited range of problem solving capacity. He has a tendency to question authority and be sceptical of others. However, his neuroticism and need for approval from others might inhibit his overt expression of his disagreement. He tends to be more lackadaisical in working towards his goals. He tends to have a low opinion about his capacity and considers himself inept to succeed.

Conclusion

Assessment indicated personality traits suggestive of passive aggression and anxious avoidant. It reveals him to have feelings of inferiority which he attempts to compensate by being dominant with others he considers inferior to him. There is a strong need to be accepted resulting in him conforming to a group by engaging in behaviour which may not be in keeping with his personality. Hence a diagnosis of mixed personality disorder was made.

Management

Admission was considered for diagnostic clarification, rationalization of medications and psychological management. He was initially continued on Sertraline 100mg and Clonazepam was gradually tapered off. Clarification of history from parents, serial mental status examinations and observation in different settings including ward, occupational therapy unit and sessions did not reveal any obsessive compulsive quality to his symptoms. Hence, Sertraline was tapered and stopped.

Rapport was established with the patient. His distress was acknowledged. He was reassured regarding his complaint of urinary urge as a sign of anxiety and not OCD. He was educated how anxiety can result in physiological changes and preoccupation with it causes more anxiety resulting in more frequent physiological changes. He encouraged to normalize this symptom and avoid giving it attention and continue with his task at hand. Gradually, his urge to urinate reduced and did not cause any distress

at the time of discharge. He was able to attend occupational therapy (OT) sessions without taking a break in between.

He expressed anxiety in social situations, feelings of low self-confidence and low self-esteem. Over the course of his stay, Mr. N's behaviour did not reveal the anxiety symptoms he had initially expressed. He was able to make friends easily – same and opposite gender and there was no social anxiety observed. Passive aggressive tendencies and strong need to conform to his social group was observed from his behaviour. This was confirmed by the personality testing. Cognitive behavioural therapy was initiated and he was taught to identify, evaluate and give up with alternative explanations for his negative cognitions. He was started on an activity schedule which he was able to follow fairly consistently.

He was regular to occupational therapy sessions and actively participated in all the activities. At times, he was reported to not conform to the rules and regulations of the activities.

Parents were explained about the absence of OCD and they were educated about the nature of personality factors, poor coping with his course and inability to adjust with his peers - contributing towards his current problems. Parents were found to be inconsistent in their parenting resulting in interpersonal problems between all three family members. This was reflected to them and the implications of this on Mr. N's behaviour was explained to them.